REQUEST FOR STAKEHOLDERS COMMENTS
From the Connecticut Dietetic Association

After reviewing the "REQUEST for STAKEHOLDER COMMENT; Evaluation and Design of an Insurance Exchange in Connecticut"document, the Connecticut Dietetic Association offers the following comments pertinent to section "D": *"Increase access to high quality health insurance*" with some implications for section "F": *"Self-sustaining financing of benefits*." We have compiled information below related to inclusion of nutrition services as provided by a Registered Dietitian in the health benefit package being developed as part of the CT Health Insurance Exchange. The CT Dietetic Association (CDA) also participated in the SustiNet process, specifically the Quality and Provider Advisory, Medical Home and Preventive Health Care Advisory Committees, all of which acknowledge the importance of nutrition interventions in the prevention and treatment of chronic diseases.

State health insurance exchanges, created by the Affordable Care Act ("ACA"), organize the health insurance market while facilitating the availability, choice and purchase of health insurance for enrollees. CDA supports these the principles in that ensure consumers receive quality and effective care. However, CDA believes there is a key omission in the recommendations that will significantly impact the health of CT citizens and impact healthcare costs for the state. The omission is the provision of medical nutrition therapy (nutrition services) provided by registered dietitians.

Both the SustiNet PHCA committee and Section 1302 of the ACA recommend a comprehensive package of preventive services. The general benefit categories are preventive and wellness services and chronic disease management, maternity and newborn care, mental health and substance-use disorder services, and pediatric services, amongst other categories. Preventive health services in the ACA (and SustiNet) stipulate health insurance coverage shall provide coverage for, and shall not impose any cost sharing requirements for evidence-based items or services that have in effect a rating of 'A' or 'B' in the current recommendations of the United States Preventive Task Force ("USPSTF").(1,2)

Support of Medical Nutrition Therapy (MNT) in the CT Model:

In these USPSTF recommendations, nutrition counseling /MNT for adult patients with hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic disease is noted. Nutrition counseling can be delivered by primary care clinicians or by referral to other specialists, such as Registered Dietitians ("RDs"). Evidence supports the provision of MNT to improve health outcomes of the public for chronic conditions including, but not limited to obesity, hypertension, pre- diabetes, HIV/AIDs, and kidney disease.

Additionally, the role of nutrition in health promotion, disease prevention and disease management has progressively become a more significant public health issue. Overweight and morbid obesity run rampant in the United States. In fact, both are is considered to be one of the leading causes of deaths in adults. For the prevention of chronic diseases, nutrition and diet must be incorporated into a daily regimen. Nutrition has a role in the prevention of the leading causes of death including cardiovascular disease, type 2 diabetes, hypertension, osteoporosis, and certain cancers. Four of the top six leading causes of death--diseases of the heart, cancer, cerebrovascular disease and diabetes--can be influenced by diet and nutrition. (3)

As evidenced by USPSTF and the preventive role of nutrition, CDA strongly believes that Medical Nutrition Therapy provided by a Registered Dietitian or other qualified health care provider should be included in the essential summary of benefits outlined in the Connecticut"s state health insurance exchanges.

II. Registered Dietitians as Cost-Effective Providers

RDs provide the most cost-effective, nutrition services and they are the most qualified healthcare professionals to provide MNT. The RD should be included as providers of MNT in covered benefits. MNT is distinctly different from nutrition education and requires advanced skills beyond those of other health professionals. According to the Institute of Medicine, "the Registered Dietitian is currently the single identifiable group of health-care professionals with standardized education, clinical training, continuing education and national credentialing requirements necessary to be directly reimbursed as a provider of nutrition therapy." (5)

Medical Nutrition Therapy (MNT) is defined as: "nutritional diagnostic, therapy, and counseling services for the purpose of disease management which are furnished by a registered dietitian or nutrition professional…" (source Medicare MNT legislation, 2000). MNT is a specific application of the Nutrition Care Process in clinical settings that is focused on the management of diseases. MNT involves in-depth individualized nutrition assessment and a duration and frequency of care using the Nutrition Care Process to manage disease. Nutrition Education/counseling is reinforcement of basic or essential nutrition-related knowledge. MNT provided by RDs for prevention, wellness and disease management can improve a consumer's health and increase productivity and satisfaction levels through decreased doctor visits, hospitalizations, and reduced prescription drug coverage. RDs provide vital food, dietary and nutrition services, while promoting health and well-being to the public. By using their expertise and extensive training, both academically and clinically, RDs deliver care that is coordinated and cost-effective in a variety of chronic diseases, such as obesity, hypertension, diabetes, disorders of lipid metabolism, HIV infection, unintended weight loss in older adults and chronic kidney disease.RDs apply evidence-based nutrition practice guidelines that enable them to provide quality and researched based nutrition interventions. (6)

Additionally, according to Wolf, et. al, for every dollar an employer invests in the lifestyle modification program for employees with diabetes, the employer would see a return of $2.67 in productivity. MNT provided by RDs also impact productivity; the study indicated the RD-led lifestyle intervention provided to patients with diabetes and obesity reduced the risk of having lost work days by 64.3% and disability days by 87.2%, compared with those receiving usual medical care. (7) Other studies likewise demonstrate the cost-savings and benefits of RD-provided MNT.

III. Recommended changes to the Benefit package

In light of the aforementioned reasons for the inclusion of MNT into the benefits' package, CDA provides the following comments for consideration by the CT Health Insurance Exchange Committee when creating or modifying further recommended standards for essential health benefits. To optimize health among CT citizens, MNT services provided by RDs should be included in all "standard benefit packages" developed for the health insurance exchange.
CDA recommends that RDs and/or nutrition professionals (based on Scope of Practice in CT) be included in the definition of providers. CDA proposes that nutrition services/MNT, and RDs as providers of those services, be included in the prevention services coverage category. The inclusion of MNT in preventive services, such as annual wellness visits (8), provides an avenue of prophylactic treatment for chronic conditions and improves lifestyle behaviors that lead to chronic conditions. (9,10)

For example, treatment of obesity requires complex, early and consistent intervention.
There is a significant difference between nutrition interventions when individuals are overweight versus when they become obese. If they receive early intervention with MNT and nutrition counseling, many patients may not get to a stage of obesity that puts them at risk for other diseases. Therefore, exclusion of MNT/RD services is not only inconsistent with quality care, but also fails to take into account long-term effects of excessive weight on health and the potential cost-savings from

prevention. (11)

The list of services that will not be covered include weight loss programs. This restricts CT citizens suffering from obesity, diabetes mellitus, cardiovascular risks and other chronic diseases (i.e., hypertension)from accessing beneficial services. Management of weight and weight loss are critical when treating patients who suffer from such conditions. Obesity, in many cases, is the etiology of co-morbid conditions. Treatment strategies include treating the chronic disease while also the underlying cause, which is more often than not, being overweight. (12) As a result, MNT, including nutrition services and weight loss programs conducted by RDs, should not be excluded from any essential standard benefits for coverage.

IV. Conclusion

MNT has science- based evidence to support it's role, in managing chronic disease, therefore MNT needs to be included in the standard essential health benefits' package for the CT health insurance exchange. RDs are the most qualified practitioners to provide such services given their expertise and training. Utilizing RDs as providers of MNT, in conjunction with such services being covered by insurance carriers, there will be a significant impact on both the rates of chronic disease and subsequent cost-savings may result.

We urge the CT Health Insurance Exchange Committee to take into account these considerations as they work to develop and implement metrics and protocols for standard essential covered benefits. We will compile additional references and supporting documents to bring to our stakeholder meetings. We look forward to working with the Exchange Committee to improve health and wellness among CT citizens.

Thank your for your time and consideration!
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1. ACA, Section 2713.
2. http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm
3. American Diabetes Association. Nutrition Principles and Recommendations in Diabetes. Diab Care 27:S36-S46, 2004; Brown J, Byers T, Thompson K et al. Nutrition during and after cancer treatment. CA Cancer J Clin 2001;51:153-187; Byers T, Nestle M, McTiernan et al. Guidelines on nutrition and physical activity for cancer prevention. CA Cancer J Clin 2002;52:92-119; National Cancer Institute. National Institute of Health. Overview of Nutrition in Cancer Care. http://www.nci.nih.gov/cancertopics/pdq/supportivecare/nutrition. Accessed December 28, 2004; NIH Publication No. 03-4082, Facts about the DASH Eating Plan, United States Department of Health and Human Services, National Institutes of Health, National Heart, Lung, and Blood Institute http://www.nhlbi.nih.gov/health/public/heart/hbp/dash/; Public Health Service, United States Department of Health and Human Services. Bone Health and Osteoporosis: A Report of the Surgeon General. Rockville MD: Office of the Surgeon General, October 2004.
4. Committee on Nutrition Services for Medicare Beneficiaries. "The Role of Nutrition in Maintaining Health in the Nation's Elderly: Evaluating Coverage of Nutrition Services for the Medicare Population." Washington, DC: Food and Nutrition Board, Institute of Medicine; January 1, 2000 (published).
5. *The Role of Nutrition in Maintaining Health in the Nation's Elderly: Evaluating Coverage of Nutrition Services for the Medicare Population.* Committee on Nutrition Services for Medicare

Beneficiaries Food and Nutrition Board. INSTITUTE OF MEDICINE, Washington, D.C. 1999.
6. Grade 1 data. ADA Evidence Analysis Library,http:www.adaevidencylibrary.com/topic.cfm?cat=3949.
Definitions: Strength of the Evidence for a Conclusion/Recommendation Grade I, "Good evidence is defined as: "The evidence consists of results from studies of strong design for answering the questions addressed. The results are both clinically important and consistent with minor exceptions at most. The results are free of serious doubts about generalizability, bias and flaws in research design. Studies with negative results have sufficiently large sample sizes to have adequate statistical power."
7. Wolf AM, Conaway MR, Crowther JQ, et al. Translating lifestyle intervention to practice in obese patients with type 2 diabetes: Improving Control with Activity and Nutrition (ICAN) study. Diabetes Care. 2004; 27:1570–6.
8. P.L. 111-148 (Patient Protection and Affordable Care Act), citing RDs as one of the medical professionals who can provide annual wellness visits.
9. Implications of the Diabetes Prevention Program (DPP) and Look AHEAD Clinical Trials for Lifestyle Interventions: J Am Diet Assoc. 2008 April; 108 (4 Suppl 1): S66-S72 (August 14, 2009).
10. For example, interventions based on nutrition therapy or physical activity and intensive lifestyle interventions, involving both nutrition therapy and physical activity are effective at reducing incidence of type 2 diabetes. Interventions involving pharmacotherapy are also effective at reducing incidence of type 2 diabetes, however, in all but one study, lifestyle interventions were more effective than pharmacotherapy. Grade 1 Data.
http://www.adaevidencelibrary.com/conclusion.cfm?conclusion_statement_id=250570&highlight=lifestyle&home =1:.
11. Studies show MNT provided by a RD to overweight and obese adults for less than six months yields significant weight losses of approximately one to two pounds per week. MNT provided from six to twelve months yields significant mean weight losses of up to 10% of body weight with maintenance of this weight loss beyond one year. Overweight/obese individuals, who received MNT provided by RDs (an average of 2.6 visits) in addition to an obesity-related health management program that included physician visits, nursing support, education materials and tools, were more likely to achieve clinically significant weight loss than individuals who did not receive MNT. American Dietetic Association Food & Nutrition Conference & Expo 2009, Grade 1 data.
12. Flegel KM, Carroll M, Ogden C, Johnson CL. (2002). Prevalence and trends in overweight among US adults, 1999-2000. J Amer Med Assoc, 288(14): 1723-1727, 2002; Ogden CL, Flegel KM, Carroll MD, Johnson CL. (2002). Prevalence and Trends in Overweight Among US Children and Adolescents, 1999-2000. J Amer Med Assoc., 288 (14): 1728- 1732; Mokdad AH, Marks JS, Stroup DF, Gerberding JL. (2004). Actual causes of death in the United States, 2000. J Amer Med Assoc., 291(10): 1238-1245; The Surgeon General's Call To Action To Prevent and Decrease Overweight and Obesity http://surgeongeneral,gov/topics/obesity/default.htm.